APPENDIX A

[redacted]

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1 MEDICARE (Medicare #)	Medicaid (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)

1a INSURED'S I D NUMBER (FOR PROGRAM IN ITEM 1)		
2 PATIENT S NAME (Last Name First Name Middle Initial)	3 PATIENT'S BIRTH DATE MM DD YY SEX M F	4 INSURED'S NAME (Last Name First Name Middle Initial)
5 PATIENT S ADDRESS (No Street)	6 PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7 INSURED'S ADDRESS (No Street)
CITY / STATE	8 PATIENT STATUS Single Married Other	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)	Employed Full-Time Student Part-Time Student	ZIP CODE / TELEPHONE (INCLUDE AREA CODE)
9 OTHER INSURED S NAME (Last Name First Name Middle Initial)	10 IS PATIENT'S CONDITION RELATED TO	11. INSURED'S POLICY GROUP OR FECA NUMBER
a OTHER INSURED S POLICY OR GROUP NUMBER	a EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b OTHER INSURED S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? PLACE (State) YES NO	b EMPLOYER'S NAME OR SCHOOL NAME
c EMPLOYER S NAME OR SCHOOL NAME	c OTHER ACCIDENT? YES NO	c INSURANCE PLAN NAME OR PROGRAM NAME
d INSURANCE PLAN NAME OR PROGRAM NAME	10d RESERVED FOR LOCAL USE	d IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12 PATIENT S OR AUTHORIZED PERSON S SIGNATURE I authorize the release of any medical or other information necessary to process this claim I also request payment of government benefits either to myself or to the party who accepts assignment below

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below

SIGNED _____

14 DATE OF CURRENT MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a I D NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19 RESERVED FOR LOCAL USE		20 OUTSIDE LAB? YES NO $ CHARGES
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1 2 3 4		22 MEDICAID RESUBMISSION CODE ORIGINAL REF NO 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25 FEDERAL TAX I D NUMBER SSN EIN	26. PATIENT S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt claims, see back) YES NO
28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN # GRP #

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

APPENDIX A

APPENDIX B

APPROVED OMB NO. 0938-0997

	2							3 PATIENT CONTROL NO	4 TYPE OF BILL
	5 FED TAX NO	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV'D	8 N-C'D	9 C I D	10 L R D	11	
12 PATIENT NAME		13 PATIENT ADDRESS							
14 BIRTHDATE	15 SEX	16 MS	17 DATE	ADMISSION 18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO
24	CONDITION CODES 25	26	27	28	29	30			31
32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE		34		35	36 OCCURRENCE SPAN CODE	FROM THROUGH
a									A
b									B
									C

38	39 VALUE CODES CODE	AMOUNT		41 VALUE CODES CODE	AMOUNT
	a				a
	b				b
	c				c
	d				d

	42 REV CD	43 DESCRIPTION	44 HCPCS RATES	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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17								17
18								18
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20								20
21								21
22								22
23								23

	50 PAYER	51 PROVIDER NO	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56
A							
B							
C							

57 **DUE FROM PATIENT**

	58 INSURED'S NAME	59 P REL	60 CERT - SSN - HIC - ID NO	61 GROUP NAME	62 INSURANCE GROUP NO
A					
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B				
C				

67 PRIN DIAG CD	68 CODE	69 CODE	OTHER DIAG. CODES 72 CODE	74 CODE	76 ADM. DIAG CD	77 E-CODE	78

79 P C	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE		82 ATTENDING PHYS. ID	
							a
	OTHER PROCEDURE CODE	DATE			OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID
							a
							b
a	84 REMARKS					OTHER PHYS. ID	a
b							b
c						85 PROVIDER REPRESENTATIVE	86 DATE
d						X	

UB 92 HCFA-1450 OCR/ORIGINAL 790-0202

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

APPENDIX B

APPENDIX C

Exemplary Voice Commands

```
     -----Function-----    -----Voice Command-----
     .Add vmAppExit, "Exit Computer", "", ""
     .Add vmAppExit, "Computer Exit", "", ""

     .Add vmUserLogin, "Hello Computer", "", ""
     .Add vmUserLogin, "Log Me In", "", ""
     .Add vmUserLogin, "Log In", "", ""

     .Add vmUserLogout, "Goodbye Computer", "", ""
     .Add vmUserLogout, "Log Me Out", "", ""
     .Add vmUserLogout, "Log Out", "", ""

     .Add vmProfileShow, "Show Profile", "", ""
     .Add vmProfileShow, "Show Settings", "", ""

     .Add vmPatientSelect, "Patient <1To20>", "", ""
     .Add vmPatientSelect, "Select Patient <1To20>", "", ""

     .Add vmPatientsShow, "Show Patients", "", ""
     .Add vmPatientsShow, "Patient List", "", ""
     .Add vmPatientsShow, "Case List", "", ""

     .Add vmFormsShow, "Show Forms", "", ""
     .Add vmFormsShow, "Show Protocol", "", ""
     .Add vmFormsShow, "Protocol List", "", ""

     .Add vmProtocolSelect, "_____", "", "" 'valid Protocol file name
     .Add vmProtocolSelect, "Use _____", "", "" 'valid Protocol file name

     .Add vmRecordBegin, "Begin Dictation", "", ""
     .Add vmRecordBegin, "New Dictation ", "", ""
     .Add vmRecordBegin, "Start Dictation ", "", ""
     .Add vmRecordBegin, "Begin Record", "", ""
     .Add vmRecordBegin, "New Record", "", ""
     .Add vmRecordBegin, "Start Record", "", ""

     .Add vmProtocolEdit, "Edit Protocol", "", ""
     .Add vmProtocolEdit, "Edit Form", "", ""

     .Add vmRecordHold, "Hold Patient", "", ""
     .Add vmRecordHold, "Hold Record", "", ""

     .Add vmRecordSign, "My Signature", "", ""
     .Add vmRecordSign, "Sign Record", "", ""
     .Add vmRecordSign, "Sign the Record", "", ""
     .Add vmRecordSign, "Sign Off", "", ""
```

```
        .Add vmRecordCancel, "Cancel Form", "", ""
        .Add vmRecordCancel, "Cancel Record", "", ""

5       .Add vmProtocolFieldNext, "Next Field", "", ""
        .Add vmProtocolFieldNext, "Advance", "", ""

        .Add vmProtocolFieldPrevious, "Previous Field", "", ""
        .Add vmProtocolFieldPrevious, "Go Back", "", "
```

United States Patent & Trademark Office

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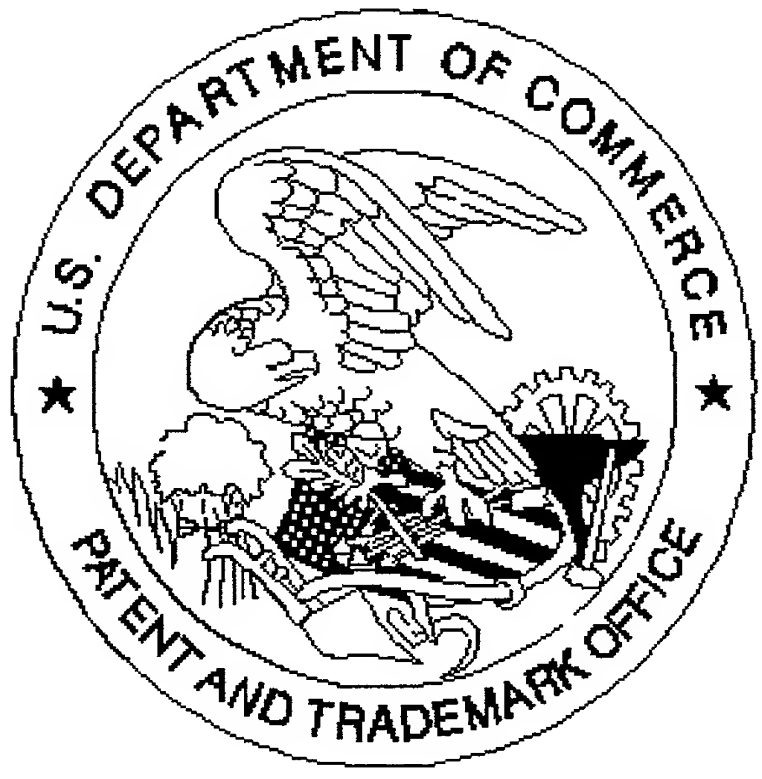

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▫ ***Scanned copy is best available.***

- Some Drawing figures are very dark.
- Pages numbered 27 to 30 as part of specification are Appendices.